



## CONCORD CHILDREN'S CLINIC PARENT REVIEW FORM

Patient Name -----

Date of birth \_\_\_\_\_ Date of Evaluation \_\_\_\_\_

Parent Concern \_\_\_\_\_

Current living arrangements \_\_\_\_\_

Behavior at home \_\_\_\_\_

Peer relations/ social skills \_\_\_\_\_

Activities & involvements \_\_\_\_\_

School history \_\_\_\_\_  At Grade Level \_\_\_\_\_  Below \_\_\_\_\_  Above \_\_\_\_\_

Current school attending \_\_\_\_\_ Grade \_\_\_\_\_

Contact person at school \_\_\_\_\_  Counselor \_\_\_\_\_  Teacher \_\_\_\_\_

Current academic process \_\_\_\_\_

Special classes' \_\_\_\_\_

Repeated grades \_\_\_\_\_

Previous testing and evaluation \_\_\_\_\_

Management strategies to current problems \_\_\_\_\_

### Family history

Yes No

Cardiac Arrhythmia  
Long or short QT syndrome  
Syncope requiring resuscitation  
Learning disability  
Alcoholism  
Bipolar  
Sudden or unexplained death of young family member  
Heart attack of a family member less than 35 yrs of age

Yes No

Cardiomyopathies  
Abnormal rhythm problems  
Marfans Syndrome  
Depression  
ADHD  
Other mental problems

### Patient History

Yes No

History of fainting or dizziness with exercise  
Chest pain for shortness of breath with exercise  
Palpitation or irregular heart beat  
History of high blood pressure  
History of heart murmur  
Head trauma

Yes No

Seizures  
Rheumatic fever  
TIC disorder  
Sleep problems  
History of heart problems

Current Meds \_\_\_\_\_

Health Supplements \_\_\_\_\_